Wisconsin State Planning Grant

HIPP Enrollment Process Review

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TABLE OF CONTENTS

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Project Summary

APS updated the 2001 Institute for Health Policy Solutions (IHPS) analysis of barriers to enrollment in the Health Insurance Premium Payment program (HIPP) to determine at what point in the process potential enrollees are "lost". It is intended that the results of this analysis will be used to improve processes and/or inform discussions related to potential targets for program expansion.

Data Sources

The primary data source for this analysis was the Employer Verification of Insurance Coverage (EVIC) statistics reports. These reports display various HIPP enrollment statistics, displayed as program inception to current month cumulative totals. The reports are maintained and updated by the EDS HIPP unit and are delivered to the Division of Health Care Financing (DHCF) on a monthly basis. Data from July 2002 through June 2004 were used in this analysis. In order to identify trends over time, the two-year analysis period was divided into 6-month increments.

The EDS HIPP unit also maintains monthly mail statistic reports. The monthly mail statistics reports are one of the data sources used to compile the EVIC statistic reports. A small number of monthly mail statistic reports were reviewed as part of this analysis.

Method and Findings

Analyze and Verify Data Sources

Method

Because the monthly mail statistic reports are a data source used to compile the EVIC statistics reports, it was assumed that the data contained in the two reports would be consistent. To test this hypothesis, monthly mail statistic reports were compared to the corresponding EVIC statistics report. One monthly report was reviewed for each of the analysis periods.

Analysis Period Label	Analysis Period Dates	Mail Statistic Month Reviewed
2002-2	July 2002-December 2002	August 2002
2003-1	January 2003-June 2003	March 2003
2003-2	July 2003-December 2003	October 2003
2004-1	January 2004-June 2004	April 2004

Findings

In nearly all cases, the data contained in the monthly mail statistic reports exactly matched the corresponding data in the EVIC statistic reports. In fact, there was only one month (August 2002) that had any incongruency between the monthly mail statistic and EVIC statistics reports, and the difference was minor.

However, in two of the four months reviewed (August 2002 and October 2003), there were inconsistencies in the EVIC statistics reports. The EVIC statistics reports are divided into sections closely approximating the enrollment decision making process. The number of

applicants 'passing' one step should be accounted for in the next step. For example, the total number of currently employed applicants with a returned EVIC form (end of step 1) should match the sum of persons processed in step 2.

The inconsistencies discovered in August 2002 data were spread throughout the report, while the error found in the October 2003 report is isolated to the cost effectiveness determination step. In fact, October's data most likely is not errant, but rather may reflect processing of a backlog of applicants (over 1,200 applicants were processed in the cost effectiveness step during this month, compared to less than 50 in an average month).

In sum, this analysis indicates that the EVIC statistics reports are not perfect. In fact, each period of analysis has at least one data inconsistency. However, these reports are likely accurate enough to support the summary-level enrollment analysis we plan to undertake.

The recent (May 2004) transition from the EVIC form and associated enrollment process to the new employment verification and Employer Sponsored Health Insurance Information (ESHI) forms and process provides an opportunity to re-visit and revise the HIPP enrollment reporting process. First, it is recommended that the reporting process be automated as manual processes are not only cumbersome, but also are inherently subject to human error. It is also recommended that routine data quality monitoring take place. This may include a 'balancing' process to ensure the internal consistency of the reports (for example, testing that the number of recipients 'passing' one step in the enrollment process matches the number represented in the subsequent step). When deviations from the usual process result in data inconsistencies, the reasons and known implications should be explained in the report.

Evaluate Barriers to HIPP Enrollment

Method

Arithmetic calculations were performed using the EVIC statistics report data (cumulative in nature) to generate statistics for each of the 6-month analysis periods. For example, per the EVIC statistics report, there were 88,520 EVICs returned from program inception through 6/30/02. By 12/31/02, 104,223 had been returned. Therefore, it was assumed that this difference of 15,703 represented EVICs submitted during the analysis period of July 2002-December 2002. This method was replicated for the other periods.

Findings

An average of 15,761 EVIC forms was returned in each 6-month period. Of those returned, between 13% and 28% indicated that the applicant is no longer employed. The percentage varied from period to period and no definitive trend was evident. Those currently employed (ranges from 72% to 87%) move to the next step in the enrollment process. In the two-year period we analyzed, 49,425 applicants (an average of 12,356 per 6-month period) were currently employed and moved on to the next enrollment step.

Half of those currently employed did not have access to family coverage. (Applicants are categorized as having no access to family coverage if they are offered no coverage at all or individual coverage only.) This finding is consistent over all the periods we analyzed. Another quarter of those currently employed had access to a self-funded plan. Program policy does not

exclude self-funded plans, per se. However, in most cases, these applicants do not proceed through the HIPP enrollment process.

Consequently, during this two-year period, only eight percent of those currently employed (3,800 of 49,425) were found to have had access to an approved plan. Table 1 provides additional summary statistics.

Table 1	2002-2	2003-1	2003-2	2004-1	Total
Of returned, percent no longer employed	25%	28%	19%	13%	
Of returned, percent currently employed	75%	72%	81%	87%	
Number moving on to next step	11,823	12,213	13,700	11,689	
Of returned and employed…					
Percent with no access to family coverage	51%	49%	53%	50%	
Percent with access to state plan	0%	3%	0%	1%	
Percent with no access to HIPAA std plan	1%	1%	1%	3%	
Percent with self-funded employer plan	22%	22%	24%	24%	
Percent with access 18 month/80% employer contribute	10%	10%	7%	5%	
Percent currently insured	7%	8%	5%	4%	
Percent in processing/follow up/unable to process	3%	2%	3%	2%	
Percent with access to employer HIPAA plan (moving on to next step)	7%	5%	7%	12%	
Number with access to employer HIPAA plan (moving on to next step)	784	617	988	1,411	3,800

After an applicant has been deemed to have access to an approved plan, the plan is evaluated to determine whether the employer's premium contribution level is in the accepted range of 40% to 79%. Over half the eligible applicants had employer contributions in the acceptable range. This percentage has not changed significantly over the period of analysis as seen in Table 2.

Table 2	2002-2	2003-1	2003-2	2004-1	Total
Of those with an approved plan, the percent with the following employer contribution…					
0-9%	18%	13%	16%	11%	
10-19%	7%	8%	7%	7%	
20-29%	8%	11%	7%	6%	
30-39%	7%	7%	7%	7%	
40-49%	8%	6%	8%	9%	
50-59%	18%	23%	22%	20%	
60-79%	31%	30%	27%	33%	
80% or more	4%	3%	6%	6%	
Percent with qualifying employer contribution (moving on to next step)	57%	59%	57%	62%	
Number with qualifying employer contribution (moving on to next step)	435	538	569	881	2,423

In the two-year period we analyzed, 2,423 applicants were currently employed, had access to an approved plan, and had an acceptable employer contribution level. However, a large percent of these never made it to the cost effectiveness determination step. To proceed to the cost effectiveness determination step, the applicant must have at least one BadgerCare-eligible child. Sixty-two percent (1,495 of 2,423) of potential HIPP enrollees did not have at least one BadgerCare-eligible child, and therefore did not proceed to the cost-effectiveness determination step.

Other reasons why applicants with access to an approved plan with an acceptable employer contribution level did not progress to the cost-effectiveness determination step are listed in Table 3. As in the EVIC statistics reports, the data are grouped by employer contribution level (40-59% or 60-79%).

Table 3

	2002-2	2003-1	2003-2	2004-1
40-59% Employer Contribution				
Percent no longer employed	0%	0%	0%	0%
Percent no longer BC eligible	17%	19%	2%	7%
Percent currently covered by employer insurance	1%	1%	0%	0%
Percent employer no longer offers coverage	0%	0%	0%	0%
Percent of cases with children not BC eligible	58%	73%	13%	63%
Percent that need additional info from employer	1%	0%	0%	3%
Percent that go on to cost effectiveness test	24%	7%	84%*	27%
Number that go on to cost effectiveness test	**46**	**17**	**1,264***	**111**
60-79% Employer Contribution				
Percent no longer employed	0%	0%	0%	0%
Percent no longer BC eligible	13%	13%	9%	8%
Percent currently covered by employer insurance	2%	1%	0%	0%
Percent employer no longer offers coverage	0%	0%	0%	0%
Percent of cases with children not BC eligible	56%	59%	64%	61%
Percent that need additional info from employer	2%	1%	3%	4%
Percent that go on to cost effectiveness test	28%	25%	23%	26%
Number that go on to cost effectiveness test	**66**	**69**	**61**	**124**

** Note: In October of 2003, 1500 EVICs were processed (this step and cost effectiveness determination), possibly as a clean-up of backlogged forms.*

During this two-year period, 1,758 applicants completed the cost effectiveness test (including 1,223 from the anomalous October 2003 backlog). In an average 6-month period, 68 applicants in the 40-59% employer contribution category and 80 applicants in the 60-79% employer contribution category completed the cost effectiveness test.

As shown in Table 4, applicants with higher employer contribution levels (60-79%) were shown to be cost effective at a higher rate than applicants with lower employer contribution levels (40-59%).

Table 4	2002-2	2003-1	2003-2	2004-1
40-59% Employer Contribution				
Percent cost effective for buy-in	7%	17%	0%	23%
Percent cost effective for future+ buy-in	22%	25%	1%	9%
Percent not cost effective	72%	58%	98%	68%
Number cost effective for buy-in now / in future	**3 / 10**	**8 / 12**	**5 / 16**	**25 / 10**
60-79% Employer Contribution				
Percent cost effective for buy-in	-6%*	16%	23%	39%
Percent cost effective for future+ buy-in	48%	48%	48%	29%
Percent not cost effective	58%	36%	30%	32%
Number cost effective for buy-in now / in future	**-4* / 32**	**11 / 33**	**14 / 29**	**48 / 36**
Total cases bought in during period	**17**	**24**	**39**	**77**
+ *Note: Governor Doyle signed legislation on July 24, 2003 making HIPP eligibility a 'qualifying event'. Employers, however, can still impose a waiting period before the applicant is eligible for health benefits. These waiting periods are the primary reason cost-effective applicants are ineligible for immediate buy-in.*				
* *Note: The statistics for this period result in a negative 'Percent cost effective for buy-in' and a negative 'Number cost effective for buy-in now / in future'. The reason for this anomaly is not evident.*				

Summary

A very small percentage of employed BadgerCare enrollees were enrolled in the BadgerCare HIPP program during this two-year period. Of the 49,425 currently employed applicants, only 157 (0.3%) were bought into the program. A number of opportunities for program expansion were discovered during the course of this analysis and are discussed below.

Individual versus Family Coverage

Half of the applicants deemed 'currently employed' did not have access to family coverage. It is likely that many of these applicants had access to individual coverage, but not family coverage. Using the EVIC statistics reports, it is impossible to ascertain the percentage of those who had access to individual coverage. There is an opportunity to increase HIPP enrollment by enrolling applicants in individual coverage if all other criteria are met (employer contribution percent, cost-effectiveness, etc.).

Self-funded Plans

A quarter of those 'currently employed' had access to a self-funded plan. Although it is reported that program policy does not exclude self-funded plans per se, it appears that these applicants do not proceed through the HIPP enrollment process. A better understanding of how to address self-funded plans (specifically as it pertains to determination of the employer contribution percent) may lead to increased HIPP enrollment.

Employer Contribution
Approximately 40% of applicants who had access to approved plans had employer contributions outside the acceptable range – the vast majority with employer contributions <40%. There may be an opportunity to increase HIPP enrollment by expanding the acceptable employer contribution range. Although applicants with lower employer contribution levels (40-59%) are less likely to be deemed cost effective than cases with higher contributions (60-78%), there may be a benefit to testing this on a case-by-case basis since the cost to determine cost effectiveness is low compared to the potential benefit cost savings.

BadgerCare-eligible Child
A large percent of those currently employed with access to an approved plan with an acceptable employer contribution level never made it to the cost effectiveness determination step because they did not have at least one BadgerCare-eligible child (62% - 1,495 of 2,423). Since having a Medicaid or BadgerCare-eligible child is a condition of BadgerCare adult enrollment, it follows that BadgerCare-eligible adults that do not have a BadgerCare-eligible child must have at least one Medicaid-eligible child. In addition to the potential cost-savings lost by not enrolling the eligible adult in employer sponsored insurance, there are savings lost by not enrolling the Medicaid-eligible children. Therefore, there is a significant opportunity to increase HIPP enrollment by enrolling cost-effective applicants (and their Medicaid-eligible children), whether or not they have a BadgerCare-eligible child.

Next Steps

For a number of reasons including resource availability, required legislative action and waiver requirements, some of the opportunities identified above may be more feasible to implement than others. For those changes that are deemed practical by the DHCF, APS will undertake additional analyses to explore the potential impact of the changes on HIPP enrollment and associated program savings. These additional analyses will be completed following the completion of the program-wide cost effectiveness evaluation (in progress) and the case-by-case cost effectiveness evaluation (scheduled to begin in January 2005).